



# NOTICE OF ACTION HEALTHY INDIANA PLAN (HIP)

State Form 53453 (11-07) / HIP 2521

Name of Applicant/Recipient	FSSA Telephone and FAX (800) 403 - 0864	
Address	Case Number	
	Application Date	Mailing Date of Notice

☐ You have been conditionally approved for the Healthy Indiana Plan (HIP).

Your health coverage will begin on the first day of the month after your health plan receives your first payment to your POWER account. In a few days, your health plan will send you the bill for your first POWER account payment. If you do not make your payment by the due date, your HIP application will be denied.

Your monthly POWER account payment is \$ . The State will fund the balance of your POWER account up to the \$1100 maximum.

The amount was calculated at ☐ 2% ☐ 3% ☐ 4% ☐ 4.5% ☐ 5% of your monthly countable income of: \$

☐ The monthly countable income is the total for you and your spouse who also applied for HIP. The POWER account payment was divided by 2, allowing half for each of you.

The following deductions were allowed:

Package C Premium \$	MEDWorks Premium \$	Medicare Premium \$
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☐ You have been conditionally approved for the Healthy Indiana Plan (HIP).

Your health coverage will begin on the first day of the month after your health plan acknowledges your account. In a few days, you will receive another notice stating the begin date of your health coverage. The State will fund your \$1100 POWER account.

The amount was calculated at ☐ 2% ☐ 3% ☐ 4% ☐ 4.5% ☐ 5% of your monthly countable income of: \$

The following deductions were allowed:

Package C Premium \$	MEDWorks Premium \$	Medicare Premium \$
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☐ You are approved for enrollment in the Healthy Indiana Plan.

Effective Date of Health Coverage

☐ Your application for the Healthy Indiana Plan was denied.

Reason(s) for the denial:

Legal Support

☐ The following action is being taken on your HIP benefits:

Effective Date

☐ Your HIP benefits will be terminated.

Reason(s) for the action

☐ Your HIP POWER payment will change to:

Legal Support

IMPORTANT INFORMATION IS ON PAGE 2 OF THIS NOTICE

When you are approved for the Healthy Indiana Plan (HIP), your enrollment period is 12 months. Your benefits will start on the effective date stated on Page 1 of this Notice and will continue for 12 months without regard to any changes in your income or family size. If you move, please call the Service Center number on Page 1 of this Notice to report your new address. This will ensure that our records are current so that important mailings reach you without delay

You must report the following changes in your circumstances within 10 days of when the change occurs:

- You become pregnant. Because your HIP benefits do not include pregnancy care, it will be necessary to transfer your health coverage to Hoosier Healthwise.
- You become insured under other health insurance, either private or Medicare.
- You have access to your employer-sponsored health insurance.
- You move out of the State of Indiana to live.

During your 12-month enrollment period you can specifically ask for ONE recalculation of your POWER account payment due to a change in your income. This limitation does not apply to changes in your family size or to loss of employment, or loss of other income source.

You must make your POWER account payment every month. If you stop making your payment, your HIP benefits will be terminated and you will not be allowed to re-enroll in the program for one year.

If this notice states that your benefits will be terminated, you may be eligible for Medicaid in another category. The Medicaid categories are listed below. If you have more information about your case, contact the FSSA Service Center within ten (10) days of the mailing date of this Notice. (Thirteen (13) days if this Notice is received by mail.) In addition to meeting the categorical requirement, an individual must also meet income and/or resource requirements, which vary for each category.

Newborns  
Low-Income Families  
Transitional Medical Assistance  
Children age 18, 19, 20 living with parent or other relative  
SSI recipients in low-income families  
Children under age 21 living in psychiatric facilities  
Children under age 19  
Aged, Blind, Disabled Receiving Room & Board Assistance (RBA)

Individuals age 65 and older  
Blind Individuals  
Disabled Individuals  
Wards of the Department of Child Services  
Refugees  
Medicare beneficiaries  
Individuals who were in foster care on their 18<sup>th</sup> birthday  
Pregnant Women

#### IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR HIP BENEFITS

You have the right to file an appeal and have a fair hearing. An appeal must be filed within thirty (30) days of the effective date of the action or the date of this notice, whichever is later. The time limits for filing an appeal are extended by 3 days if this notice is received by mail.

HIP benefits will continue without change if you appeal an action to reduce or stop your benefits prior to the effective date of the action. If the hearing decision is that the action explained on this notice was correct, you will be required to repay the extra benefits you received. You may specifically request that your benefits not be continued pending the appeal decision. If you make this request, the action explained on this notice will occur.

If you wish to appeal, send a letter with your signature, along with a copy of this entire notice if possible, to the Family and Social Services Administration/Document Center / PO Box 1810 / Marion, IN / 46952, or to MS 04 / Family and Social Services Administration / Hearings and Appeals Section / 402 W. Washington St. / Indianapolis, IN 46204.

You will be notified in writing of the date, time and place for the hearing. You may represent yourself or have someone else represent you such as an attorney, friend or relative. If you wish to have legal representation and cannot afford it, you may call the Indiana Legal Services office serving your area. Their web site address is [www.indianajustice.org](http://www.indianajustice.org).

**FOR QUESTIONS AND TO REPORT CHANGES, CALL FSSA:  
1-800-403-0864.**